GENETICS

Nursing, obedience, and complicity with eugenics: a contextual interpretation of nursing morality at the turn of the twentieth century

M Berghs, B Dierckx de Casterlé, C Gastmans

J Med Ethics 2006;**32**:117–122. doi: 10.1136/jme.2004.011171

This paper uses Margaret Urban Walker's ''expressive collaborative'' method of moral inquiry to examine and illustrate the morality of nurses in Great Britain from around 1860 to 1915, as well as nursing complicity in one of the first eugenic policies. The authors aim to focus on how context shapes and limits morality and agency in nurses and contributes to a better understanding of debates in nursing ethics both in the past and present.

See end of article for authors' affiliations

Correspondence to: Chris Gastmans, Centre for Biomedical Ethics and Law, Catholic University of Leuven, Kapucijnenvoer 35, B-3000 Leuven, Belgium; Chris.Gastmans@med.kuleuven.be

Received 10 November 2004
In revised form 10 May 2005
Accepted for publication 11 May 2005

Any description and interpretation of morality needs to take into account contextual factors. In arguing for such a contextual/ethical position, we have been influenced by the philosopher Margaret Urban Walker[1–3] who in her work has focused on the way that context shapes and limits morality. In this sense Walker's understanding of morality has been greatly influenced by care ethicists, such as Joan Tronto,[4] with whom she has collaborated.[2] Like Tronto, Walker too gives a critique of ethics by illustrating and interpreting the social, historical, and cultural realities and contexts from which morality springs. Walker's originality, however, lies in the fact that she not only gives a descriptive analysis of the contexts of practices of morality but also outlines a method for normative critique of those moral practices.

Walker elucidates a method of moral inquiry that she calls ''expressive collaborative'', which, ''prescribes an investigation of morality as a socially embodied medium of mutual understanding and negotiation between people over their responsibility for things open to human care and response'' (Walker,[1] p 9). This means that morality is expressed in interpersonal contexts, it ''arises out of and is reproduced or modified in what goes on between or among people'' (Walker,[1] p 10). Moreover, it is collaborative in the sense that, ''we construct and sustain it together'' (Walker,[1] p10), although not always in chosen or equal terms, and any research into morality also needs to engage with these real moral practices.

The ''expressive collaborative'' method of moral inquiry consists of four hypotheses, which the authors will be using as a philosophical framework to examine and illustrate the morality of nurses in Great Britain from around 1860 to 1915. The authors chose the period 1860 to 1915 because it illustrates the beginning of a professionalisation and a new ethical reflection with regard to nursing. Furthermore, this period was also marked by medical advances that led to new ethical dilemmas for nurses, such as complicity in one of the first eugenic policies. The ''expressive collaborative'' model allows us to engage in a descriptive analysis of how moral agency occurs and how it is formed in interpersonal as well shared social contexts.

Firstly, we examine Nightingale's nursing theory against the background of the Christian ethos of the Victorian era, implementing Walker's first hypothesis that:

> morality occurs in real human practices, and we need to try and understand these practices in the social contexts in which they occur (Walker,[1] p 16).

Secondly, we examine the multiple ways that the virtue of obedience can be understood in Nightingale's nursing theory, to illustrate Walker's second hypothesis that:

> the practices characteristic of morality are practices of responsibility (Walker,[1] p 16).

Thirdly, we take up Walker's third hypothesis that:

> morality is not socially modular (Walker,[1] p 17)

to illustrate how the moral practice of obedience is not autonomous but related to other social practices, which entails a certain ambiguity in the virtue of obedience.

Lastly we take up the concrete example of nursing complicity in eugenic policies to illustrate Walker's last hypothesis, which she states is a consequence of the first three assumptions. She argues that:

> Moral theorizing and moral epistemology need to be freed from the impoverishing legacies of ideality and purity that make most of most people's moral lives disappear, or render those lives unintelligible (Walker,[1] p18).

Walker's[1] expressive collaborative model is thus a philosophical model that allows us to

give an interpretation of moral life that can function both descriptively and normatively. Descriptively, the aim is to give an interpretation and/or reveal what ''morality'' is. This description can entail ''an empirically saturated reflective analysis of what is going on in actual moral orders'' and/or it can also entail ''many different kinds of factual researches, including documentary, historical, psychological, ethnographic, and sociological ones'' (Walker,[1] p 11). Normatively, the aim is to suggest some of the important purposes of morality and the practices on which it depends for better or worse. In this essay we concentrate mainly on the descriptive research function of Walker's model by focusing on how context shapes and limits morality in nurses in Great Britain from around 1860 to 1915.

The Christian ethos of the Victorian era and nursing practice and morality

The beginnings of modern nursing as we understand the term today began with the efforts of Florence Nightingale. In her monumental work *Notes on Nursing: What it is and What it is Not*,[5] first published in 1859, Nightingale expounded the first real systematic theory of what nursing was. Using Walker's model as a philosophical framework, we implement Walker's first hypothesis that morality occurs in real human practices. Human practices that reveal ''...complexly differentiated social orders and individually varied lives'' (Walker,[1] p 15), giving a picture of how morality is shaped in differing contexts. We illustrate how the societal context of the Christian ethos of the Victorian era in Great Britain shaped Nightingale's theory of nursing and ethics as human practices.

Nursing as practice

In the preface to *Notes on Nursing*, Nightingale notes that every woman at some time in her life has been responsible for the personal health of another, making nursing a uniquely feminine practice. In noting this long tradition of care that women themselves have created, she recognises that she cannot dictate to such a tradition and states: ''I do not pretend to teach her how, I ask her to teach herself and for this purpose I venture to give her some hints'' (Nightingale,[5] p 1). Nightingale feels that nursing care has to be learnt through the practices of nursing itself, and that after a nurse has learnt the basics she needs to reflect on these hints.

A new morality in nursing

Before Florence Nightingale's *Notes on Nursing*, nursing as a profession was not held in high esteem: a physician of the time described nurses as: ''...dull, unobservant, untaught women; of the best it could be said that they were kindly and careful and attentive in doing what they were told''.[6] The dominant public perception of nurses during Nightingale's time was that they were either drunks or prostitutes, for a ''refined woman'' would never be allowed to work outside of the home.[7] Such a public perception of what a nurse was stands in remarkable contrast not only to the life and work of Florence Nightingale but also to what she felt the moral identity of a nurse was.

In order for nursing to develop, Nightingale argued, nursing had to attract educated nurses who would bring a new heartfelt commitment to care for others. Although Nightingale believed that nurses were called to nursing, she felt that the demands of nursing practice meant that nurse education had to be of a continuing practical, intellectual, and especially moral nature.[5] Nightingale saw the main object of nurse training as being the development of character and self discipline, with moral training being more important than mere academic education: ''you cannot be a good nurse without being a good woman'' she was fond of saying.[8] The emphasis in training nurses was on character formation in line with Nightingale's idea that nursing was a Christian calling.

Nursing as a religious calling

The hospitals of the day were not the stereotypical ''squalid pits of despair'' that typified the workhouses, and hence reformers such as Nightingale saw their concern not as solely being ''medical or sanitary, or simply humanitarian'' but fundamentally as a religious ''Christianising mission''.[9] Nurses, through their constant care at the bedside of the ill, were in the best position to offer salvation to the poor, sick, and dying.

Nightingale felt very strongly that nursing was a religious calling from God and was a self defining moral and religious practice. It was only open to those who felt a deep seated altruism, which led them to dedicate their entire lives to aiding humanity. As Nightingale herself states:

> but more than this, she must be a religious and devoted woman; she must have respect for her own calling, for God's precious gift of life is often literally placed in her hands (Nightingale,[5] p 71).

It was for this reason that not any woman could be a nurse, but only a woman who had a virtuous character.[7]

To understand why a nurse's morality was so important, it is helpful to highlight Nightingale's notion of disease. Nightingale understood disease as an expression of the deviation of the patient from Nature: Nature she understood as being the expression of God's supreme will. Disease was due to the fact that fresh air, light, warmth, cleanliness, quiet, and a proper diet were needed by the patient. Hence disease was a restorative process of the patient trying to regain a lost union with God's will by returning to a natural as well as ethical harmony. All nursing could accomplish—and it was no small achievement—was to put the patient into the best possible condition for nature to effect its plan of cure. The nurse, by aiding the patient to restore himself to this union with God's will, was not only acting on a patient's physiology but also aiding a patient ethically and spiritually.[10–12]

A hierarchy of skills

Victorian hierarchical religious and militaristic models of instruction also influenced Nightingale's nursing theory and ethics. In the early days of nursing, caring nurses, although ''called to nursing,'' still had to be formed as nurses by being taught the necessary observational skills, to observe principles of health, sanitation, and to have a caring and disciplined attitude. Discipline, which in Nightingale's terms is ''the essence of moral training'',[5] fostered the full development of a nurse's potential both as a practising nurse and as a spiritual person. Nightingale felt that nurses had to have discipline and it was on this foundation that their ethical, spiritual, practical, and intellectual skills rested.[13 14] The spiritual and ethical virtues of a nurse took hierarchical priority, the practical skills coming second, and the intellectual skills last. Comments about nurses, in both hospital records and the nursing press of the time, draw attention to Nightingale's idea that a nurse's character was more important than theoretical knowledge and more important even than education.[15] Likewise, complaints about nurses were mostly about their personal qualities and how these affected practice of nursing.[16]

An all encompassing commitment of care

For Nightingale, nursing was a religious calling of an all inclusive character, requiring a total commitment of body, mind, and soul. Nurses had to see a patient as a person in a

holistic sense, with intellectual, emotional, social, and spiritual components, a person with whom one was required to form a relationship. The interpersonal and reciprocal relationship that a nurse had with a patient was the essence of nursing practice for Nightingale.[5] This meant that in nursing one was not concerned with the ''illness per se'' but with one's personal caring relationship to the patient as a person.[17] The relationships formed in the context of the practice of nursing illustrated why morality was crucial to Nightingale's nursing theory.

The virtue of obedience

Engaging in an analysis based on Walker's[1] second hypothesis, that ''the practices of morality are practices of responsibility'', we examine how nursing responsibilities are enacted in terms of the virtue of obedience against the background of Nightingale's theory of nursing in the context of the Christian ethos of the Victorian era. Walker explains that practices of responsibility ''...implement commonly shared understandings about who gets to do what to whom, and who is supposed to do what for whom'' (Walker,[1] p16).

Examining the virtue of obedience of that time, and how nurses interpret that virtue, is a way of exposing and understanding nursing responsibilities in terms of to whom nurses feel they are accountable and for what tasks. This illustrates the ''scope and limits'' of their moral agency, revealing what nurses care about, how they care, who becomes the authority to judge that care, and how their agency is constructed through the social orders as well as divisions of labour in the Victorian era.

Obedience as a demarcation of two differing roles

Pointing out in *Notes on Nursing* that nurses had their own body of tasks and knowledge, Florence Nightingale first elucidated that there were distinctions to be made between the role of the physician and the role of the nurse. Nurses did not have to mimic the physician's focus on medicine but had to focus on providing good care. Providing good care could not, however, happen in a vacuum, and although nurses had their own special tasks, they needed to learn from, listen to, and be obedient aides to the physician. The demarcation of two differing roles with their own particular tasks illustrates Walker's understandings of morality as practices of responsibility, located in shared understandings about who gets to do what to whom, and who is supposed to do what to whom.[1]

Helpmeets and handmaidens

In Florence Nightingale's letters to her nurses, one of the main virtues that Nightingale states as being important is the virtue of obedience.[15 18–20] Nightingale actively encourages nurses to be the ''helpmeets'' of physicians and not ''the arrogant equal of men''.[15 21] Obedience, seen in its historical context, thus reveals how nurses had to deal with hierarchical power relations and were accountable to a physician.

Yet, obedience viewed in such a context also illustrates why nurses felt they had to be obedient and reveals the nature of what they cared about as well as who judged their care. Sellman[22] quotes Nightingale as saying she felt that nurses had to be the ''helpmeets'' or ''handmaidens'' of physicians for three reasons. Firstly, Nightingale argued, up until that point in history, nurses had never followed the orders of physicians—for example, when medicines needed to be given to patients. Thus it was morally imperative that nurses regain the trust and confidence of the physician and patient by listening to and following the physician's orders. Secondly, physicians knew more about sanitation and how to implement it, an issue that had been ignored by nurses. Lastly, Sellman suggests that the stipulation of obedience also reflected a closet acceptance of male dominance in a hospital environment, which it was impossible to uproot.

Obedience as a hallmark of professional etiquette

The social order and divisions of labour in a hospital also reinforced the virtues of obedience in a nurse, because obedience was a requirement of the professional etiquette in a hospital.[16] In the Victorian era, a professional etiquette was deemed essential to diffuse the tensions and social constraints of working with those of another race, gender, and class. Although the sexes rarely mixed, neither did the classes, and thus obedience to authority was deemed important to ensure the proper functioning of a hospital and patient care. Bradshaw[16] also makes it clear that etiquette is furthermore needed to:

> maintain ''affective neutrality'', the emotional detachment needed to safeguard the professional relationship from being affected by personal preferences which may cloud judgments (Bradshaw,[16] p 327).

Obedience as a diplomatic skill

Although the structure of the social order and divisions of labour were rigid, nurses expressed their moral agency in the way that they assigned, accepted, deflected, and modified practices of responsibility. Nightingale's personal correspondence to her matrons nuances ideas of nurses as helpmeets, as she cunningly argues that ''her'' matrons have to let the physicians slowly get used to the idea of nursing reforms, as well as letting the physicians think they are the ones to first suggest them.[23] Nightingale was thus trying to teach her nurse's diplomatic skills in order to manipulate and influence the very medical authorities they had to obey.[23]

Never blind obedience?

For Nightingale,[5] obedience was never supposed to be blind obedience but a professional interaction between physician and nurse in which a physician took into account a nurse's concerns about her patient or even her institution. This, however, describes an ideal situation of nurse and physician, but medical paternalism and sexist attitudes were a problem for nurses at the turn of the 20th century. The way that responsibilities were distributed and enforced meant that some people had advantages and power over others. Continuing to regard nurses as ''handmaidens'' of physicians was very favourable to the medical establishment as a whole, and kept it supplied with a free source of labour that was often exploited.[24]

The ambiguities of obedience

Taking up Walker's third hypothesis, that ''morality is not socially modular,'' we illustrate how the moral practice of obedience is not ''autonomous'' but related and defined by other social practices.[1] Walker argues that: ''Moral practices, in fact, cannot be extricated from other social practices, nor moral identities from social roles and institutions in particular lifeways (Walker,[1] p 17). Obedience, a central virtue in the social contexts of nursing education and nursing training, because it is not only intertwined with, but also effected through, social understanding entails a certain ambiguity. This ambiguity arises mainly because of the divisions of labour that constitute hierarchical power relations such as those between nurse and physician and the way those power relations work. Obedience defined in terms of hierarchical divisions of labour entailed that obedience in differing social contexts of nursing could mean either obedience as a duty to care or obedience in terms of a slavish passivity or subservience. Such interpretations stood in tension to Nightingale's nursing theory, which stressed the importance of nursing as freely undertaken religious calling

to care, but which did not espouse a blind obedience to orders.

Obedience as a duty to care

Moral accountability was constructed in terms of obedience through the way caring was defined, practised, and implemented. Caring in the early days of nursing was understood in terms of self discipline. Through discipline and following orders in a strict hierarchy, nurses in training school had to learn the qualities of ''cleanliness, neatness, obedience, sobriety, truthfulness, honesty, punctuality, trustworthiness, quickness, and orderliness'' (Bradshaw,[16] p 323).

These qualities were to be formed by and demonstrated through the knowledge and skills that a nurse learned in regard to her patient. Training—for example, often emphasised a ''right'' or ''correct'' way to do things, which nurses had to follow strictly.[24] A duty to care became associated with an obedience to a strict discipline to do things in the ''right'' way.

Defining caring work in terms of practices of self discipline and an all encompassing duty to a patient was not without risks for nurses. Although caring fundamentally shapes nursing activity, nursing was organised with ''the expectation that practitioners would accept a duty to care, rather than demand a right to determine how they would satisfy this duty'' (Nightingale,[14] p 133). This entailed that the personal cost of caring work was a heavy one, with the ''missionary'' character of the work expected to be its own reward. The duty of care was realised in terms of the hierarchical social limitations and expectations of a woman's role in society at that time.

Obedience as passivity and subservience

The fact that nurses were all women certainly contributed to the fact that virtues such as passivity and subservience were not only encouraged but also demanded. Moreover, many of the practical requirements of nursing were not yet standardised, nor were any regulatory or institutional mechanisms in place to dictate such standardisations.[24]

An authoritarian model molded and socialised nurses to be more passive and submissive so that they could work well, both in the hospitals and home environments, where such behaviour was required. The authoritarian model was also tied into social control of nurses, who were mainly young women and thus needed to be socially disciplined, conditioned, and controlled much like a wife, daughter, or sister in the Victorian home had to be.[15] Obedience defined in terms of the duty of care, passivity, and subservience entailed ambiguities as nursing morality came to be defined and affected by the dominant hierarchies and power relations of the Victorian social world.

The morality of the nurse and complicity in eugenics

The concrete example of nursing complicity in eugenic policies illustrates Walker's last hypothesis. The hypothesis is a consequence of the first three assumptions.[1] She argues that: ''Moral theorising and moral epistemology need to be freed from the impoverishing legacies of ideality and purity that make most of most people's moral lives disappear, or render those lives unintelligible'' (Walker,[1] p 18). By which she means that morality exists, albeit imperfectly, in ''real human social spaces in real time that are not ideal or noumenal''. This entails that understandings or ''interpretations of morality in societies as well as in moral philosophy have to include information about human social worlds and forms of interpersonal recognition'' (Walker,[1] p 18). We thus describe nursing morality as existing in real human social space, in a specific historical time and context. We also note that in order to understand why nurses' morality became problematic we must first gain an insight into the sociocultural world in which their morality was constructed. Historically, nurses were obliged to act according to the policies and directives issued by authorities in all fields of health care. Using Walker's expressive collaborative model of practices of responsibility invites us to give ''detailed and situated descriptions'' of the expectations and negotiations surrounding assignments of responsibility of nurses in connection with eugenics. It also allows us to show how morality works through interpersonal understandings and to expose how changes in morality appear as patterns of responsibility change.

Eugenics in Great Britain

Although the roots of eugenics go back to ancient Greece, it only really began to gather public support at the turn of the 20th century.[25] In countries such as the United States, Germany, and Great Britain eugenics became a popular as well as scientific movement.

Sir Francis Galton, a cousin of Charles Darwin, coined the term eugenics in *Inquiries into Human Faculty and its Development*.[26] Galton elucidated that ''eugenics'' meant the '''science' of improving the human stock by giving the more suitable races or strains of blood a better chance of prevailing speedily over the less suitable'' (Galton,[26] p 765).[27] Galton believed that the human race could control its own evolution. In this control and evolution of the human race, Galton believed that the emphasis lay on social planning, preventive medicine, and the study of heredity.[28]

Eugenics has both a positive and a negative strain. Positive eugenics required that people with ''positive'' or ''desirable'' traits be encouraged to procreate for the betterment of the human race. Negative eugenics required that human beings with ''negative'' or ''undesirable'' genetic traits be discouraged from procreation. Intelligence and character were seen as ''desirable'' genetic traits, and despite the fact that these traits were importantly linked to cultural, historical, political, and social norms and biases, it was claimed by the scientific establishment that having such genetic traits was a criterion that could be defined as strictly biologically ''desirable''.[25]

In Great Britain, involvement in the Boer war (1899–1902) fuelled eugenic discourses in terms of the physical and intellectual capacities of recruits for the war. At the same time, a fear that Great Britain's imperial superiority was being endangered led to a eugenic concern with socio-economic problems at home, which were seen as a danger to the wellbeing of the white race. This expressed itself in concern with identifying, managing, and limiting the breeding of the ''feeble minded'', which the Radnor Commission was appointed to investigate in 1904.[29] By 1907, the British had founded the Eugenics Education Society to educate the public about eugenics and sensitise them to its importance.[27] The Eugenics Education Society lobbied the general public and parliament intensively, using the findings of the Radnor Commission, published in 1908, to ensure that the Mental Deficiency Act of 1913 would be passed. The Mental Deficiency Act established a procedure for identifying ''mental defectives'' and gave local authorities the right to institutionalise these people.

Eugenics and the morality of a nurse

From around the end of the 19th century and the beginning of the 20th century, eugenics came to be seen as a necessary part of nursing. Numerous bulletins about the Eugenics Education Society as well as articles on eugenics appeared in the *British Journal of Nursing,* linking the morality of a nurse, in terms of obedience, to the practice of eugenics. The Nurses Social Union, writes that the very future of the eugenic movement depended on the education of nurses in eugenics.[30] Nurses with their ''exceptional facilities and

qualifications'' were needed ''practically'' for the betterment of humanity and their nation.

The very definition of what it was to be a nurse at the turn of the 20th century in Great Britain was linked to a nurse conforming to the servile and unquestioning role of the ''handmaiden'' to the state's eugenic policies. At this early stage, eugenics was mainly connected with public health nursing, with nurses becoming part of state policies to manage the socioeconomic problems of the time in terms of a regulation of the poor.

> Nurses played a major role in the regulation of poverty through the supervision of the poor in the workhouses and in the community...the application of nursing knowledge structures and disciplines, the use of time and space as well as gathering information about individualised bodies and comparing them to others. The comparisons allow nurses to establish ''normality''. As a consequence, the ''deviant'' individual becomes a target for surveillance and intervention (Gastaldo, *et al*,[31] p 234).

Midwives in particular were being encouraged by medical physicians to view themselves as eugenicists, as illustrated in an article entitled *Midwives as eugenicists*.[32] Yet, although nurses had an important duty to impart eugenic principles that duty was limited in that it was subservient to the physician's authority.

Nurses and negative eugenics

Many positive eugenic policies were beneficial in the sense that they formed the basis of public health campaigns that educated the general public about health, heredity, and procreation. Nurses participated in such campaigns, by—for example, educating new mothers on how to best feed their baby so it grew healthily. By contrast, negative eugenic policies and legislation argued that the genetically ''defective'' or ''deviant'' were a threat to the public's health and wellbeing.[25 27 33]

By 1912 the first negative eugenic ideas begin to appear in the *British Journal of Nursing* and by August 23, 1913, the Mental Deficiency Act was enacted, providing ''the legal basis for the compulsory detention of large numbers of disabled people, identified by doctors, social workers and colleagues as mental defectives''.[34] ''Mental deficiency'' was defined in such broad terms, however, that it covered people with learning difficulties, the disabled, the diseased, alcoholics, criminals, the poor, and prostitutes [and so forth].[29 34]

The ethical standards by which nurses were selected and trained were used against working class men, children, and especially women who did not measure up to such standards and did not fit into the same virtuous mould as the nurse, so as to segregate those people from the public and forcibly detain them in institutions.[29 35] The detrimental effect of forced long term institutional care on patients, based on eugenics, as well as nurse involvement in such practices, has been well documented.[29 33–36]

All institutions employed nurses to care for the ''mentally defective''. Nurses were furthermore required to follow special training schemes in order to obtain the proper qualifications.[36] Men ran most institutions but there were cases of matrons setting up their own small institutions.[34] Nurses felt they were behaving ethically by identifying those who they believed needed long term care, and caring for patients in institutions.[34] In the *British Journal of Nursing*, a picture is painted of the mental health nurse, mainly following Nightingale's inspiration, in terms of her character, which ideally would have at its root ''a religious feeling''. The article goes on to point out that a nurse's work was ''practical'' and ''moral'' and that she would carry out this work with ''unobtrusive devotion'' to practical action.[37] This entailed that nurses were required to follow orders in the carrying out of the practical work of nursing.

Yet practical nursing aims to cure a patient, but nurses found they lacked the special kind of skills needed by people placed in long term care under the terms of the Mental Deficiency Act:

> the main reason is that cure is the main idea in nursing of sickness, whereas in the nursing of the underdeveloped, what the world calls ''cure'' is rarely obtained, and people who aim for this get dissatisfied by their inability to achieve a definite end (Stevens,[34] p 76).

Nurses thus found themselves in a morally problematic and difficult situation at the turn of the 20th century; the ambiguities present in the very virtue of obedience entailed that they became complicit in one of the first negative eugenic policies.

Implications for nursing ethics

In this paper we have argued that any description and interpretation of nursing morality needs to take into account contextual factors. Engaging in an analysis and critique of how contextual factors affect morality is important not only to illustrate how action and behaviour are limited by context but also to address the ethical challenge of prescribing a specific behaviour in each context, despite the context itself. We were influenced by Margaret Urban Walker, who has focused on how context shapes and limits morality and through an analysis of context outlines a method for normative critique of moral practices.[1–3] The history of nurse involvement in eugenics illustrated how that morality was influenced by the specific social and historical time and context in which the nurses were living.

There has not been much research on nurses' involvement in the early state policies of eugenics. Even when the history of eugenics is examined with regard to the present dangers of eugenics, nurse involvement is never explicitly examined.[38] Most scholarship and research tends to focus on how eugenics came to a head in the evils committed by nurses during the euthanasia programmes in the Nazi era in Germany.[39–41] With regard to the involvement of nurses in the Nazi euthanasia programmes, Walker's method of moral inquiry could perhaps open up new perspectives and give fresh insights into the contexts of the ethical dilemmas nurses faced and how they made ethical decisions to comply or resist.

Walker's model of moral inquiry does not only provide new perspectives for the involvement of nurses in ethics/sensitive practices in the past. Current empirical research in nursing ethics has pointed out how important it is to adequately reflect the moral voices and concerns of nurses and the importance of the context of their ethical decisions in nursing practice. This has been highlighted, in—for example, empirical research on nursing attitudes toward euthanasia.[42] Such research findings illustrate the importance of contextual factors in how nurses determined a standpoint on euthanasia. In this regard, we argue that perhaps Walker's insights could further help us develop empirical and ethical research to give answers to questions about why and how nurses get involved in euthanasia practices today. New insights from the past and the present are important, because euthanasia is conducted illegally in many countries. Even in countries where strict laws regulate euthanasia practices, such as the Netherlands and Belgium, research has shown that nurses are still involved in illegal practices.[43] In a recent nationwide study, it was found that nurses administered

lethal drugs in 58.8% of euthanasia cases in healthcare institutions in Belgium, mostly without the attendance of the prescribing physician.[44] It cannot be ruled out that, in some cases, nurses feel averse toward administering lethal drugs, but feel obliged to do so because of their subordinate position to the physician.

Although we adopt a stance of caution in light of the fact that not much ethical research has been undertaken in this area of nursing ethics, we hope that a critical illustration of the interconnections between moral practices and the differing contexts that shape virtues such as obedience at a personal, institutional, and professional level will inform nursing ethics and help nurses to understand the virtue of obedience today, in order to enhance their potential for moral action.

Authors' affiliations

M Berghs, C Gastmans, Centre for Biomedical Ethics and Law, Catholic University of Leuven, Leuven, Belgium
B Dierckx de Casterlé, Centre for Health Services and Nursing Research, Catholic University of Leuven, Leuven, Belgium

REFERENCES

1 **Walker UM**. *Moral understandings. A feminist study in ethics*. New York and London: Routledge, 1998.
2 **Walker UM**, ed. *Mother time. Women, aging, and ethics*. Lanham, Boulder, New York and Oxford: Rowman and Littlefield Publishers, 1999.
3 **Walker UM**. *Moral contexts*. Lanham, Boulder, New York and Oxford: Rowman and Littlefield Publishers, 2003.
4 **Tronto J**. Moral boundaries. A political argument for an ethic of care. New York: Routledge, 1993.
5 **Nightingale F**. In: Stevens Barnum B, eds. *Notes on nursing. What it is and what it is not*. Philadelphia: J B Lippincott, 1992.
6 **Schuyler CB**. Florence Nightingale. In: Stevens Barnum B, eds. *Notes on nursing. What it is and what it is not*. Philadelphia: J B Lippincott, 1992:3–17.
7 **Bishop AH**, Scudder JR. The practical, moral, and personal sense of nursing. A phenomenological philosophy of practice. Albany, NY: State University of New York Press, 1990.
8 **Baly ME**. Florence Nightingale and the nursing legacy. London: Croom Helm, 1986:25.
9 **Summers A**. Ministering angels. *History Today* 1989;**39**:31–7.
10 **Rosenberg CE**. Florence Nightingale on contagion. The hospital as moral universe. In, Rosenberg CE, eds. *Healing and history. Essays for George Rosen*. New York, Watson Publishing, 1979:116–36.
11 **Dolan JA**. *Nursing in society. A historical perspective* [15th ed]. Philadelphia: Saunders, 1983.
12 **Widerquist JG**. The spirituality of Florence Nightingale. *Nurs Res* 1992;**41**:49–55.
13 **Nightingale F**. Notes on matters affecting health. Subsidiary notes as to the introduction of female nursing into military hospitals in peace and war. London: Harrison and Sons, 1858.
14 **Nightingale F**. *Observation on the evidence contained in the stational returns*. London: The Royal Commission on the Sanitary State of the Army in India, 1863.
15 **Lorentzon M**. Socializing nurse probationers in the late 19th and early 20th centuries—relevance of historical reflection for modern policy makers. *Nurse Educ Today*, 2003;**23**:325–31.
16 **Bradshaw A**. Competence and British nursing. A view from history. *J Clin Nurs*, 2000;**9**:421–9.
17 **Fitzpatrick JF**. Reflections on Nightingale's perspective on nursing. In: Stevens Barnum B, eds. *Notes on nursing. What it is and what it is not*. Philadelphia: J B Lippincott, 1992:18–22.
18 **Nightingale F**. *Letter to nurses*. London Metropolitan Archives: Nightingale Collection, 1874.
19 **Nightingale F**. *Letter to nurses*. London Metropolitan Archives: Nightingale Collection, 1878.
20 **Nightingale F**. *Letter to nurses*. London Metropolitan Archives: Nightingale Collection, 1888.
21 **Nightingale F**. *Letter to nurses*. London Metropolitan Archives: Nightingale Collection, 1900.
22 **Sellman D**. The virtues in the moral education of nurses: Florence Nightingale revisited. *Nurs Ethics* 1997;**4**:3–11.
23 **Lorentzon M**, Brown K. Florence Nightingale as ''mentor of matrons'': correspondence with Rachel Williams in St Mary's Hospital. *J Nurs Manag*, 2003;**11**:266–74.
24 **Reverby S**. The duty or the right to care? Nursing and womanhood in historical perspective. In, Abel EK, Nelson MK, eds. *Circles of care. Work and identity in women's lives*. New York, State University of New York Press, 1990:132–49.
25 **Kevles DJ**. Eugenics I. Historical aspects. In, Reich WT, eds. *Encyclopedia of bioethics*. New York, Simon and Schuster Macmillan, 1995:765–70.
26 **Galton F**. *Inquiries into human faculty and its development*. London: Dent, Everyman's Library, 1919.
27 **Kevles DJ**. In the name of eugenics. Genetics and the uses of human heredity. New York: Penguin Books, 1985.
28 **Dowbiggin I**. A merciful end. The euthanasia movement in modern America. Oxford: Oxford University Press, 2003.
29 **Walmsley J**. Women and the mental deficiency act of 1913: citizenship, sexuality, and regulation. *Br J Learn Disabil* 2000;**28**:65–70.
30 **The Nurses' Social Union**. Eugenics. *Br J Nurs* 1912;**49**:500–1.
31 **Gastaldo D**, Homes D. Foucault and nursing. A history of the present. *Nurs Inq* 1999;**6**:231–40.
32 *Br J Nurs* 1913;**51**(suppl):302–3S.
33 **Ion RMN**, Beer MD. Valuing the past: the importance of an understanding of the history of psychiatry for healthcare professionals, service users, and carers. *Int J Ment Health Nurs* 2003;**12**:237–42.
34 **Stevens ARA**. Women superintendents: the contribution of Margaret MacDowell and other women managers of mental deficiency institutions in England. *Br J Learn Disabil* 2000;**28**:71–7.
35 **Goodman J**. Reflections on researching an archive of disability: Sandlebridge, 1902–1935. *Educational Review* 2003;**55**:47–54.
36 **Mitchell D**. Parallel stigma? Nurses and people with learning disabilities. *Br J Learn Disabil*, 2000;**28**:78–81.
37 **The nursing and midwifery conference: Mental and nerve work**. *Br J Nurs* 1914;**52**:443–4.
38 **Iredale R**. Eugenics and its relevance to contemporary health care. *Nurs Ethics*, 2000;**7**:205–14.
39 **Aly G**, Roth KH. The legalisation of mercy killings in medical and nursing institutions from 1938–1941. *Int J Law Psychiatry* 1984;**7**:145–63.
40 **Benedict S**. Nurses participation in the ''euthanasia'' programs of Nazi Germany. *West J Nurs Res* 1999;**21**:246–63.
41 **McFarland-Icke BR**. *Nurses in Nazi Germany. Moral choice in history*. Princeton: Princeton University Press, 2003.
42 **Verpoort C**, Gastmans C, De Bal N, *et al*. Nurses' attitudes to euthanasia: a review of the literature. *Nurs Ethics* 2004;**11**:349–65.
43 **De Beer T**, Gastmans C, Dierckx de Casterlé B. Involvement of nurses in euthanasia: a review of the literature. *J Med Ethics* 2004;**30**:494–8.
44 **Bilsen JJ**, Vander Stichele RH, Mortier F, *et al*. Involvement of nurses in physician assisted dying. *J Adv Nurs* 2004;**46**:583–91.